Physician Related Services

Provided by:

Physicians, Mid-Level Practitioners, Podiatrists, Laboratories, Imaging Facilities, Independent Diagnostic Testing Facilities, and Public Health Clinics

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

March 2008

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My Medicaid Provider ID Number:

My CHIP Provider ID Number:

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Mountain-Pacific Quality Health Foundation

For prior authorization for certain services (see the *PASSPORT and Prior Authorization* chapter in this manual), contact MPQHF:

Phone:
(800) 262-1545 X5850 In state
(406) 443-4020 X5850 Out of state and Helena
Fax:
(800) 497-8235 In state
(406) 443-4585 Out of state and Helena

Send written inquiries to:
Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

Vaccines for Children

(406) 444-5580

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Client Information Website www.dphhs.mt.gov/hpsd/medicaid/medrecip/medrecip.htm	• Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
Center for Disease Control and Prevention (CDC) web site www.cdc.gov/nip	Immunization and other health information
Parents Lets Unite for Kids (PLUK) www.pluk.org	This web site gives information on PLUK – an organization designed to provide support, training, and assistance to children with disabilities and their parents.
Medicaid Mental Health and Mental Health Services Plan www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm	Mental Health Services information for Medicaid and MHSP

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be submitted with every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This form is the only form Medicaid accepts for abortion services.

All forms required for abortions can be copied from *Appendix A Forms*, can be ordered using the *Medicaid Form Order* sheet in the *General Information For Providers* manual, or downloaded from the *Provider Information Web Site* (see *Key Contacts*).

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood and explained to the client the prescribing information for mifepristone.

Cosmetic services (ARM 37.86.104)

Medicaid covers cosmetic services only when it can be demonstrated that the condition has a severe detrimental effect on the client's physical and psychosocial wellbeing. Mastectomy and reduction mammoplasty services are covered only when medically necessary. Medical necessity for reduction mammoplasty is related to signs and symptoms resulting from macromastia. Medicaid covers surgical reconstruction following breast cancer treatment. Before cosmetic services are performed, they must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Services are authorized on a case-by-case basis.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (ARM 37.86.2201 – 2221)

The Well Child EPSDT program covers all medically necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages (see the *Well Child EPSDT* chapter in this manual). Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School based services

All prior authorization and PASSPORT approval requirements must be followed. See the *PASSPORT and Prior Authorization* chapter in this manual.

Family planning services (ARM 37.86.1701)

Family planning services include the following:

- Initial visit
- Initial physical examination
- Comprehensive history
- Laboratory services
- Medical counseling
- Annual visits
- Routine visits

Medicaid covers prescription contraceptive supplies, implantation or removal of subcutaneous contraceptives, and fitting or removal of an IUD and fitting of a diaphragm. Approval by the PASSPORT provider is not required for family planning services. See the *Completing a Claim* chapter in this manual for PASSPORT indicators. Specific billing procedures must be followed for family planning services (see *Billing Procedures*).

Home obstetrics (ARM 37.85.207)

Home deliveries are only covered on an emergency basis (see *Definitions*) by a physician or licensed midwife.

Immunizations

The Vaccines For Children (VFC) Program makes available at no cost to providers selected vaccines for eligible children 18 years old and under. Medicaid will therefore pay only for the administration of these vaccines (oral or injection). VFC covered vaccines may change from year to year. For more information on the VFC program and current VFC covered vaccines, call the Department's Immunization Program at (406) 444-5580 or refer to the most recent VFC provider notice.

Medicaid does not cover pneumonia and flu vaccines for clients with Medicare Part B insurance because Medicare covers these immunizations.

Infertility (ARM 37.85.207)

Medicaid does not cover treatment of infertility.

Prescriptions (ARM 37.86.1102)

- Drugs are limited to a 34-day supply.
- No more than two prescriptions of the same drug may be dispensed in a calendar month except for the following:
  - Antibiotics
  - Schedule II and III drugs
  - Antineoplastic agents

- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements. For more details on each service listed in the following table, please contact the prior authorization contact listed.
- For a list of prescription drugs that require PA, see the *PA Criteria for Prescription Drugs* table later in this chapter.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- Prior authorization criteria forms for most services are available on the Provider Information website (see Key Contacts)
- When PA is granted from Mountain Pacific Quality Health Foundation, providers will receive notification from both the Foundation and the Claims Processing Unit. The *Prior Authorization Notice* from the Claims Processing Unit will have a PA number. This PA number must be included on the claim.

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements

• **All transplant services**
• **Out-of-state hosptial inpatient services**
• **All rehab services**
	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Required information includes:
		  • Client's name
		  • Client's Medicaid ID number
		  • State and hospital where client is going
		  • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis.

• **Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)**
 	
(For emergency ambulance transport services, providers have 60 days following the service to obtain authorization.)
	Mountain-Pacific Quality Health Foundation
	Medicaid Transportation
	P.O. Box 6488
	Helena, MT 59604
	
	Phone:
	(800) 292-7114
	Fax:
	(800) 291-7791
	E-Mail:
	ambulance@mpqhf.org
		• Ambulance providers may call, leave a message, fax, or E-mail requests.
		• Required information includes:
		  • Name of transportation provider
		  • Provider's Medicaid ID Number
		  • Client's name
		  • Client's Medicaid ID number
		  • Point of origin to the point of destination
		  • Date and time of transport
		  • Reason for transport
		  • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
		• Providers must submit the trip report and copy of the charges for review after transport.
		• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.

• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** (406) 443-4020 X5850 Helena (800) 262-1545 X5850 In/out-of-state **Fax:** (406) 443-4585 Helena (800) 497-8235 In/out-of-state	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Circumcision**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Circumcision requests are reviewed on a case-by-case basis based on medical necessity when one of the following occurs:
		  • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated.
		  • Balanitis
		  • Urinary obstruction
		  • Urinary tract infections

• **Dispensing and fitting of contact lenses**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 In/out-of-state
	(800) 624-3958 In state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Sight cannot be corrected to 20/40 with eyeglasses

• **Prescription Drugs** (For a list of drugs that require PA, refer to the *PA Criteria for Prescription Drugs later in this chapter.*)	Drug Prior Authorization Unit Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** (406) 443-6002 Helena (800) 395-7961 In/out-of-state **Fax:** (406) 443-7014 Helena (800) 294-1350 In/out-of-state	• Refer to the *PA Criteria for Prescription Drugs* table in this chapter for a list of drugs that require PA. • Providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is in *Appendix A: Forms*. • The prescriber (physician, pharmacy, etc.) may submit requests by mail, telephone, or FAX to the address shown on the *PA Criteria for Specific Services* table.

• **Maxillofacial / Cranial Surgery**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Surgical services are only covered when done to restore physical function or to correct physical problems resulting from:
		  • Motor vehicle accidents
		  • Accidental falls
		  • Sports injuries
		  • Congenital birth defects
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Medicaid does not cover these services for the following:
		  • Improvement of appearance or self-esteem (cosmetic)
		  • Dental implants
		  • Orthodontics

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Blepharoplasty**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Reconstrutive blepharoplasty may be covered for the following:
		  • Correct visual impairment caused by drooping of the eyelids (ptosis)
		  • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure)
		  • Treat periorbital sequelae of thyroid disease and nerve palsy
		  • Relieve painful symptoms of blepharospasm (uncontrollable blinking).
		• Documentation must include the following:
		  • Surgeon must document indications for surgery
		  • When visual impairment is involved, a reliable source for visual-field charting is recommended
		  • Complete eye evaluation
		  • Pre-operative photographs
		• Medicaid does not cover cosmetic blepharoplasty

• **Botox Myobloc**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• For more details on botox criteria, coverage, and limitations, visit the Provider Information website (see *Key Contacts*)
		• Botox is covered for treating the following:
		Laryngeal spasm; Blepharospasm; Hemifacial spasm of the nerve; Torticollis, unspecified; Torsion dystonia; Fragments of dystonia; Hereditary spastic paraplegia; Multiple Sclerosis; Spastic hemiplegia; Infantile cerebral palsy; Other specified infantile cerebral palsy; Achalasia and cardiospasm; Spasm of muscle; Hyperhidrosis; Strabismus and other disorders of binocular eye movements; Other demyelinating diseases of the central nervous system
		• Documentation requirements include a letter from the attending physician supporting medical necessity including:
		  • Client's condition (diagnosis)
		  • A statement that traditional methods of treatments have been tried and proven unsuccessful
		  • Proposed treatment (dosage and frequency of injections)
		  • Support the clinical evidence of the injections
		  • Specify the sites injected
		• Myobloc is reviewed on a case-by-case basis

• **Excising Excessive Skin and Subcutaneous Tissue**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Required documentation includes the following:
		  • The referring physician and surgeon must document, in the history and physical, the justification for the resection of skin and fat redundancy following massive weight loss.
		  • The duration of symptoms of at least six months and the lack of success of other therapeutic measures
		  • Pre-operative photographs
		• This procedure is contraindicated for, but not limited to, individuals with the following conditions:
		  • Severe cardiovascular disease
		  • Severe coagulation disorders
		  • Pregnancy
		• Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Rhinoplasty Septorhinoplasty**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• The following do not require PA:
		  • Septoplasty to repair deviated septum and reduce nasal obstruction
		  • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction
		• Medicaid covers rhinoplasty in the following circumstances:
		  • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger
		  • Following a trauma (e.g. a crushing injury) which displaced nasal structures so that it causes nasal airway obstruction.
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Not covered
		  • Cosmetic rhinoplasty done alone or in combination with a septoplasty
		  • Septoplasty to treat snoring

• **Temporomandibular Joint (TMJ) Arthroscopy / Surgery**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Non-surgical treatment for TMJ disorders must be utilized **first** to restore comfort, and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case:
		  • Fabrication and insertion of an Intra-oral Orthotic
		  • Physical therapy treatments
		  • Adjunctive medication
		  • Stress management
		• Surgical treatment may be considered when both of the following apply:
		  • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery.
		  • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review.
		• Not covered:
		  • Botox injections for the treatment of TMJ is considered experimental.
		  • Orthodontics to alter the bite
		  • Crown and bridge work to balance the bite
		  • Bite (occlusal) adjustments

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Dermabrasion / Abrasion Chemical peel**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Services covered for the following:
		  • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined.
		  • The removal of pre-cancerous skin growths (keratoses)
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		  • Pre-operative photographs

• **Positron Emission Tomography (PET) Scans**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• PET scans are covered for the following clinical conditions: (For more details on each condition and required documentation, contact MPQHF.)
		  • Solitary pulmonary nodules (SPNs) - characterization
		  • Lung cancer (non small cell) - Diagnosis, staging, restaging
		  • Esophageal cancer - Diagnosis, staging, restaging
		  • Colorectal cancer - Diagnosis, staging, restaging
		  • Lymphoma - Diagnosis, staging, restaging
		  • Melanoma - Diagnosis, staging, restaging. Not covered for evaluating regional nodes
		  • Breast cancer - As an adjunct to standard imaging modalities for staging clients with distant metastasis or restaging clients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated
		  • Head and neck cancers (excluding CNS and thyroid) - Diagnosis, staging, restaging
		  • Myocardial Viability - Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan.
		  • Refractory Seizures - Covered for pre-surgical evaluation only.
		  • Perfusion of the heart using Rubidium 82 tracer (Not DFG-PET) - Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction Mammoplasty**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Both the Referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded.
		• **Indications for female client:**
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must indicate and support the following:
		• History of the client's symptoms related to large, pendulous breasts.
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		• **Indications for male client:**
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

PA Criteria for Medicaid Prescription Drugs

Drug	Criteria
Actiq Lozenges (fentanyl)	• No history of MAOI use within the last 30 days • Initial doses greater than 200mcg will not be approved. Initial therapy will be defined as patients not having Actiq therapy in the last 30 days • Non-cancer diagnoses will not be approved • Greater usage than 4 units of any strength per day • Authorization for existing usage in pain of non-cancer origin will be granted on an individual basis in consultation with the prescriber to prevent withdrawal syndromes.
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix.
Antiemetics Kytril Tablets and oral solution. PA required for quantities greater than 10 units in a 30-day period. Zofran Tablets and oral solution. PA required for quantities greater than 15 units in a 30-day period. Anzemet Tablets PA required for quantities greater than 5 units in a 30-day period.	For prescription exceeding monthly quantity limits for the prevention of nausea and vomiting associated with chemotherapy/radiation therapy, or for nausea and vomiting associated with pregnancy when traditional therapies have failed. Quantity limits for these and other indications will be considered on a case by case basis.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.
Avinza (Morphine sulfate extended-release capsules) PA required for quantities greater than once daily.	Requests exceeding these quantity limits will be considered on an individual basis.

PA Criteria for Medicaid Prescription Drugs (continued)

Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Toradol (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Tretinoin PA required for patients 26 years and older.	Diagnose of: • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Xanax XR (alprazolam extended-release tables)	• Xanax XR tables may be covered for patients who have not responded to adequate trials of at least two generic long-acting benzodiazepines, one of which is generic alprazolam. • Coverage of Xanax XR will be allowed for once daily dosing only.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for patients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.
Carisoprodol (Soma®) containing products	• New prescriptions—Patient must have tried and failed on at least two other centrally-acting muscle relaxants (i.e. methocarbamol, tizanidine, cyclobenzaprine, orphenadrine, chlorzoxazone or Skelaxin®). • Prior authorizations may be granted for a maximum of 84 tablets in a six-month time period. • Renewal requests—A 30-day authorization will be granted for patients currently taking carisoprodol to allow for a tapering schedule. Patients on high doses may suffer withdrawal symptoms if stopped abruptly.

PA Criteria for MHSP Prescription Drugs (continued)

Drug	Criteria
buspirone (Buspar)	• Augumentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least **two** multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	• Diagnosis of bi-polar disorder.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for patients requiring dosages where tablet splitting would be inappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.

- For bilateral x-rays, bill on separate lines, one line with modifier RT and one line with modifier LT. The exception would be codes that are described as bilateral in their code description. These are to be billed on one line with one unit.
- Imaging providers must take particular care in the use of modifiers. The TC modifier is used when only the technical portion of the service is provided. The provider who interprets the results uses modifier 26. When both technical and professional services are performed by the same provider, no modifier is required.

Billing Tips for Specific Services

Abortions

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This is the only form Medicaid accepts for abortions.

Anesthesia

- Use appropriate CPT-4 anesthesia codes.
- Do not use surgery codes with an anesthesia modifier.
- For services where codes or definitions differ between the CPT-4 and the *American Society of Anesthesiologists' Relative Value Guide*, Medicaid adopts the CPT-4 version.
- Include the total number of minutes on the claim. Medicaid will convert the number of minutes to the number of time units. Do not include the base units on the claim as the claims processing system determines the number of base units (see the *Completing a Claim* chapter in this manual).

Bundled services

Certain services with CPT-4 codes (eg., telephone advice, some pulse oximetry services) are covered by Medicaid but have a fee of zero. This means that the service is typically "bundled" with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Cosmetic services

Include the prior authorization number in on the claim (see the *Completing a Claim* chapter in this manual).

EPSDT Well Child Screens

- Bill for a complete screen using the appropriate evaluation and management (E&M) code for preventive medicine services.
- When billing for partial screens, use the appropriate preventive medicine code with modifier 52 (reduced services).
- See also the Well Child EPSDT chapter in this manual.
- For Well Child EPSDT indicators, see the *Completing a Claim* chapter in this manual.

Family planning services

Contraceptive supplies and reproductive health items provided free to family planning clinics cannot be billed to Medicaid. When these supplies are not free to the clinic, providers associated with a family planning clinic can bill Medicaid for the following items:

Item	Code
Diaphragm	A4266
Male condoms	A4267
Female condoms	A4268
Spermicide	A4269
Oral contraceptives	S4993

For family planning indicators, see the *Completing a Claim* chapter in this manual.

Immunizations

- Use codes 90465, 90467, 90471 or 90473 with modifier SL to bill for the first administration of vaccines under the Vaccines for Children (VFC) program. Use 90466, 90468, 90472, 90474 with modifier SL for subsequent VFC administrations. (For proper code assignments, refer to your CPT code manual for the code description differences.)
- There must be a VFC covered vaccine code for each unit of service billed with the above codes. Each VFC vaccine code must be billed with $0.00 charges and you do not need to report the NDC on a VFC vaccine. (For a list of VFC covered vaccines, contact the Department's immunization program at (406) 444-5580).
- No more than four diagnosis codes are necessary.
- **NOTE:** You may only bill for administration services if performed by, or under the direct supervision of, a reimbursable professional (i.e. physician, mid-level). All administration of VFC vaccines must be billed on a 1500 at no charge for the VFC supplied vaccine and the administration should have the appropriate modifier (SL) to be reimbursed for the federal mandated administration rate. (See fee schedule.)

http://medicaidprovider.hhs.mt.gov/providerpages/providertype/27.shtml#feeschedules

- **NOTE:** Human Papillomavirus (HPV/ Gardasil / 90649) is provided by (VFC) for clients ages 9 through age 18. Montana Medicaid will reimburse for the administration from age 9 and also for the vaccine from ages 19 to 27.
- **NOTE:** If a significant separately identifiable Evaluation and Management service (e.g., office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code (with the appropriate modifier) should be reported in addition to the vaccine and toxoid administration codes.
- **NOTE:** There can only be one initial administration code (90465, 90467, 90471, 90473). For each additional administration, you need to use an add-on code (90466, 90468, 90472, 90474).
- Be sure to use the appropriate modifier (SL) with each VFC administration. For example, a provider administers three vaccines: MMR, pneumococcal conjugate, and DTaP.

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12	12	03	12	12	03	11	0	90471	SL	1	10 00	1				
2 12	12	03	12	12	03	11	0	90472	SL	1	20 00	2				
3 12	12	03	12	12	03	11	0	90707		1	0 00	1				
4 12	12	03	12	12	03	11	0	90669		1	0 00	1				
5 12	12	03	12	12	03	11	0	90700		1	0 00	1				

Obstetrical services

If the provider's care includes prenatal (antepartum) and/or postnatal (postpartum) care in addition to the delivery, the appropriate global OB code must be billed. Antepartum care includes all visits until delivery, and there are different codes for specified numbers of visits. There are also different codes for antepartum and postpartum care when only one or the other is provided. Please review your CPT coding book carefully.

Reference lab billing

Under federal regulations, all lab services must be billed to Medicaid by the lab that performed the service. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or

payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.

- For medically necessary sterilizations (including hysterectomies, oophorectomies, salpingectomies, and orchiectomies), one of the following must be attached to the claim, or payment will be denied:
    - A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client (or representative, if any) and physician must sign and date Section A of this form prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). Also, for section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.
    - For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
        - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
        - The reason for the hysterectomy was a life-threatening emergency.
        - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

  When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on sterilizations, see the *Covered Services* chapter in this manual.

Surgical services

- Medicaid does not provide additional payment for the "operating room" in a physician's office. Medicaid pays facility expenses only to licensed hospitals and ambulatory surgical centers.

- ***Reporting surgical services:*** Certain surgical procedures must not be reported together, such as:
    - Procedures that are mutually exclusive based on the CPT-4 code description or standard medical practice.
    - When both comprehensive and component procedures are performed, only the comprehensive procedure must be billed.
    - When the CPT-4 manual describes several procedures of increasing complexity, only the code describing the most extensive procedure performed must be reported.

  Medicaid edits for some surgical services using Medicare's Correct Coding Initiative (CCI) edits and performs post-payment review on others. See *Coding Resources* earlier in this chapter for more information on CCI.
- ***Assistant at surgery***
    - When billing for an assistant at surgery, refer to the current Medicaid Department fee schedule to see if an assist is allowed for that procedure.
    - If an assistant at surgery does not use the appropriate modifier, then either the assistant's claim or the surgeon's claim (whichever is received later) will be denied as a duplicate service.
    - Physicians must bill assistant at surgery services using the appropriate surgical procedure code and modifier 80, 81, or 82.
    - Mid-level practitioners must bill assistant at surgery services under their own provider number using the appropriate surgical procedure code and modifier AS, 80, 81, or 82.
- ***Global surgery periods:*** Global surgery periods are time spans assigned to surgery codes. During these time spans, services related to the surgery may **not** be billed. Group practice members that are of the same specialty must bill Medicaid as if a single practitioner provided all related follow-up services for a client. For example, Dr. Armstrong performs orthopedic surgery on a client. The client comes in for a follow-up exam, and Dr. Armstrong is on vacation. Dr. Armstrong's partner, Dr. Black, performs the follow-up. Dr. Black cannot bill this service to Medicaid, because the service was covered in the global period when Dr. Armstrong billed for the surgery.
    - For major surgeries, this span is 90 days and includes the day prior to the surgery and the following services: post-operative surgery related care and pain management and surgically-related supplies and miscellaneous services.
    - For minor surgeries and endoscopies, the spans are either one day or ten days. They include any surgically-related follow-up care and supplies on the day of surgery, and for a 10-day period after the surgery.

- For a list of global surgery periods by procedure code, please see the current Department fee schedule for your provider type.
- If the CPT-4 manual lists a procedure as including the surgical procedure only (i.e., a "starred" procedure) but Medicaid lists the code with a global period, the Medicaid global period applies. Almost all Medicaid fees are based on Medicare relative value units (RVUs), and the Medicare relative value units were set using global periods even for starred procedures. Montana Medicaid has accepted these RVUs as the basis for its fee schedule.
- In some cases, a physician (or the physician's partner of the same specialty in the same group practice) provides care within a global period that is unrelated to the surgical procedure. In these circumstances, the unrelated service must be billed with the appropriate modifier to indicate it was not related to the surgery.

Telemedicine services

- When performing a telemedicine consult, use the appropriate CPT-4 evaluation and management (E&M) consult code.
- The place of service is the location of the provider providing the telemedicine service.
- Medicaid does not pay for network use or other infrastructure charges.

Transplants

Include the prior authorization number on the claim (field 23 on the CMS-1500 claim form). See the *Completing a Claim* chapter in this manual. All providers must have their own prior authorization number for the services. For details on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

Weight reduction

Providers who counsel and monitor clients on weight reduction programs must bill Medicaid using appropriate evaluation and management (E&M) codes.

Unlisted procedures

Unlisted CPT or HCPCS codes are to be sent to the Department for review. They can be sent to:

Physician-Related Services
Claim Review
P.O. Box 202951
Helena, MT 59602

Unlisted procedures are paid via the by-report methodology. See page 9.5 for more information on this method.

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999 -	**888888888** -	**11182003**
Medicaid Provider ID	Client ID Number	Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address. If you are including a copy of the claim, complete side A; if a copy of the claim is not included, complete side B.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • View the client's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim when such approval is required. See the *PASSPORT and Prior Authorization* chapter in this manual.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim (see the *PASSPORT and Prior Authorization* chapter in this manual). • Mental Health Services Plan (MHSP) claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See the *Mental Health Services Plan* manual.
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

These billing procedures also apply to the Mental Health Services Plan (MHSP). These billing procedures do not apply to the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators

Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services.
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Client Has Medicaid Coverage Only

Field #	Field Title	Instructions
Client Information		
2*	Client's Name	Enter patient's name as seen on client's Montana's Healthcare Programs information
10d, *	Client's ID	Enter the client's ID number as it appears on the client's Montana's Healthcare Programs information.
1a, 9a, 11**	Client's ID	If Client's ID is not located in 10d these three fields are searched for the number
Provider Information		
17a **	Referring Provider's Passport #	Enter Referring Provider's Passport number if a Passport client (a qualifier is not necessary).
17b **	Referring Provider's NPI #	Enter Referring Provider's NPI #
24a shaded area	NDC	Enter the qualifier, N4, followed by the NDC, units qualifier and units as described by the qualifier
24i shaded**	ID Qualifier	ZZ for the Taxonomy qualifier
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider
24j **	NPI Number, Rendering Prov	Enter NPI Number for the rendering provider.
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a*	NPI #	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter Modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

* = Required Field ** = Required if applicable

Client Has Medicaid Coverage Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Chuckie L.

3. PATIENT'S BIRTH DATE MM DD YY: 04 28 96 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406)555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY: 07 19 08 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo, M.D.

17a. 1D 9954321

17b. NPI 1234567890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 381.20
2. 474.12
3. 474.01
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 18 08		24		69436	50	1	500 00	1		ZZ	36LP000X
										NPI	1234567890
2 03 18 08		24		42830	51	2,3	450 00	1		ZZ	36LP000X
										NPI	1234567890
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 99999

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 950 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 950 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Bender 08/02/08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Anytown Surgicenter
123 Medical Drive
Anytown, MT 59999

a. NPI b.

33. BILLING PROVIDER INFO & PH # (406)555-1234

The Pediatric Center
P.O. Box 999
Anytown, MT 59999-9999

a. 9876543210 b. ZZ 400RT001X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Client Has Medicaid and Medicare Coverage

Field #	Field Title	Instructions
Client Information		
1a*	Insured's ID Number	Enter the client's Medicare ID number
2*	Client's Name	Enter patient's name as seen on client's Montana's Healthcare Programs information
10d, *	Client's ID	Enter the client's ID number as it appears on the client's Montana's Healthcare Programs information.
11d*	Is there another health benefit plan?	Check "NO."
9a, 11**	Client's Medicaid ID	If client's ID is not located in 10d these fields are searched for the number
Provider Information		
17a **	Referring Provider's Passport #	Enter Referring Provider's Passport number if a Passport client (a qualifier is not necessary).
17b **	Referring Provider's NPI #	Enter Referring Provider's NPI #
24a shaded area	NDC	Enter the qualifier, N4, followed by the NDC, units qualifier and units as described by the qualifier
24i shaded**	ID Qualifier	ZZ for the Taxonomy qualifier
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider
24j **	NPI Number, Rendering Prov	Enter NPI Number for the rendering provider.
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a*	NPI #	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter Modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider

* = Required Field ** = Required if applicable

Client Has Medicaid and Medicare Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999999999A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Jerry	3. PATIENT'S BIRTH DATE MM DD YY: 02 04 33 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Anytown STATE: MT	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555	Employed [X] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE: 999999999	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo, M.D.	17a. 1D 9954321 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 07 07 TO 12 24 07
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 486 . _____ 3. _____ . _____ 2. _____ . _____ 4. _____ . _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 07 08 12 07 08	21		99223		1	200 00	1		ZZ NPI	36LP000X 1234567890
2	12 08 08 12 08 08	21		99223		1	75 00	1		ZZ NPI	36LP000X 1234567890
3	12 09 08 12 09 08	21		99223		1	75 00	1		ZZ NPI	36LP000X 1234567890
4	12 10 08 12 10 08	21		99223		1	75 00	1		ZZ NPI	36LP000X 1234567890
5	12 13 08 12 13 08	21		99223		1	75 00	1		ZZ NPI	36LP000X 1234567890
6	12 15 08 12 15 08	21		99223		1	75 00	1		ZZ NPI	36LP000X 1234567890

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: 99999	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 575 00	29. AMOUNT PAID: $	30. BALANCE DUE: $ 575 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mary Bender 08/02/08 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION Anytown Hospital 12345 Medical Drive Anytown, MT 59999 a. NPI b.		33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Client Has Medicaid and Third Party Liability Coverage

Field #	Field Title	Instructions
Client Information		
1a**	Insured's ID Number	Enter the client's ID number for the primary carrier
2*	Client's Name	Enter patient's name as seen on client's Montana's Healthcare Programs information
9a**	Other Insured's Information	Enter the client's ID number if there are two or more third-party insurance carriers
10d, *	Client's ID	Enter the client's ID number as it appears on the client's Montana's Healthcare Programs information.
11*	Insured's Policy Number	Enter the client's ID number for the primary payer
11c*	Insured's Plan	Enter primary payer's name
11d*	Is there another health benefit besides Medicaid	Check "YES."
Provider Information		
17a **	Referring Provider's Passport #	Enter Referring Provider's Passport number if a Passport client (a qualifier is not necessary).
17b **	Referring Provider's NPI #	Enter Referring Provider's NPI #
24a shaded area	NDC	Enter the qualifier, N4, followed by the NDC, units qualifier and units as described by the qualifier
24i shaded**	ID Qualifier	ZZ for the Taxonomy qualifier
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider
24j **	NPI Number, Rendering Prov	Enter NPI Number for the rendering provider.
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a*	NPI #	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter Modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider

* = Required Field ** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	X						999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jackson, Renee P.	3. PATIENT'S BIRTH DATE MM DD YY SEX 08 31 80 M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY Anytown STATE MT	8. PATIENT STATUS Single X Married Other Employed Full-Time Student Part-Time Student	CITY STATE
ZIP CODE 59999 TELEPHONE (Include Area Code) (406)555-5555		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? PLACE (State) YES X NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE 999999999	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 01 16 08	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo, M.D.	17a. 1D 9954321 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 845.02 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 16 08 01 16 08	11		99203		1	75 00	1		ZZ NPI	36LP000X 1234567890
2	01 16 08 01 16 08	11		73610		1	45 00	1		ZZ NPI	36LP000X 1234567890
3	01 16 08 01 16 08	11		L1930		1	125 00	1		ZZ NPI	36LP000X 1234567890
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 X	26. PATIENT'S ACCOUNT NO. 123456789	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 25 00	29. AMOUNT PAID $ 20 00	30. BALANCE DUE $ 5 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mary Bender 08/02/08 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION The Foot Group 25 Medical Drive Anytown, MT 59999-9999 a. NPI b.	33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X			

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field #	Field Title	Instructions
Client Information		
1a**	Insured's ID Number	Enter the client's Medicare ID number
2*	Client's Name	Enter patient's name as seen on client's Montana's Healthcare Programs information
10d, *	Reserved for Local Use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's Policy Group	Enter the client's primary payer (TPL) ID number
11c*	Insurance Plan or Program	Enter the name of the primary payer
11d*	Is there another health benefit plan?	Check "YES."
Provider Information		
17a **	Referring Provider's Passport #	Enter Referring Provider's Passport number if a Passport client (a qualifier is not necessary).
17b **	Referring Provider's NPI #	Enter Referring Provider's NPI #
24a shaded area	NDC	Enter the qualifier, N4, followed by the NDC, units qualifier and units as described by the qualifier
24i shaded**	ID Qualifier	ZZ for the Taxonomy qualifier
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider
24j **	NPI Number, Rendering Prov	Enter NPI Number for the rendering provider.
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a*	NPI #	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter Modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider
29*	Amount Paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance Due	Enter the balance due (the amount in field 28 less the amount in field 29).

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999999999A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Olsen, Karen Z.	3. PATIENT'S BIRTH DATE MM DD YY: 11 07 62 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Anytown STATE: MT	8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	CITY STATE
ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555		ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999A
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE: 999999999	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY: 06 23 07 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo, M.D.	17a. 1D 9954321 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 690.10 2. 078.10 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 20 07	12 20 07	11		17110		1,2	79 20	1		ZZ NPI	36LP000X 1234567890
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
99-9999999 [ ] [X]	123456789	YES [X] NO [ ]	$ 79 20	$ 32 00	$ 47 20

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Mary Bender 08/02/08 SIGNED DATE	Steven Sloan, MD P.O. Box 999 Anytown, MT 59999-9999 a. NPI b.	(406) 555-1234 Steven Sloan, MD P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field #	Field Title	Instructions
Client Information		
1a**	Insured's ID Number	Enter the client's Medicare ID number
2*	Client's Name	Enter patient's name as seen on client's Montana's Healthcare Programs information
10d, *	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid information.
11*	Insured's Policy Group	Enter the client'd ID number for the primary payer.
11c*	Insurance Plan or Program	Enter the name of the other insurance plan or program (i.e. BlueCross Blue Shield, New West, etc.)
11d*	Is there another health benefit plan?	Check "YES."
Provider Information		
17a **	Referring Provider's Passport #	Enter Referring Provider's Passport number if a Passport client (a qualifier is not necessary).
17b **	Referring Provider's NPI #	Enter Referring Provider's NPI #
24a shaded area	NDC	Enter the qualifier, N4, followed by the NDC, units qualifier and units as described by the qualifier
24i shaded**	ID Qualifier	ZZ for the Taxonomy qualifier
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider
24j **	NPI Number, Rendering Prov	Enter NPI Number for the rendering provider.
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a*	NPI #	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter Modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider
29*	Amount Paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the Medicare EOMB attached to the claim.
30*	Balance Due	Enter the balance due (the amount in field 28 less the amount in field 29).
11*	Insured's Policy Group	Enter the client's primary payer (TPL) ID number

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, George P.

3. PATIENT'S BIRTH DATE: 05 13 35 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Supplemental Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 599.0 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 07 07	05 07 07	11	0	99212		1	50 00	1		ZZ NPI	36LP000X 1234567890
2 05 07 07	05 07 07	11	0	81002		1	7 00	1		ZZ NPI	36LP000X 1234567890
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 393 00

29. AMOUNT PAID: $ 314 40

30. BALANCE DUE: $ 78 60

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Bender 08/02/08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Steven Sloan, MD
P.O. Box 999
Anytown, MT 59999-9999

a. NPI b.

33. BILLING PROVIDER INFO & PH # (406) 555-1234

Steven Sloan, MD
P.O. Box 999
Anytown, MT 59999-9999

a. 9876543210 b. ZZ 400RT001X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Time units

A unit of time for anesthesia is 15 minutes, though Medicaid does pay for partial units. Providers enter the number of minutes on the claim; the claims processing contractor then converts the minutes to time units.

Base units

Base units are adopted by Medicaid from the schedule of base units used by Medicare, which in turn is reflects base units calculated by the American Society of Anesthesiologists. Providers do not enter the number of base units on the claim.

Fee calculation

For a particular service, Department payment is calculated as follows:

(Time units + base units) x anesthesia conversion factor = payment

For anesthesia for a wrist operation (01820), for example, the number of base units is 3. If the anesthesiologist spends 60 minutes with the patient then payment would be:

[4 + 3] x conversion factor of $26.25 = $183.75

The only exceptions are several codes for which time units do not apply. These codes are paid via the RBRVS fee schedule, with the relative values being set by the Department so that the fee equals the number of anesthesia base units x the anesthesia conversion factor.

Transitional conversion factor

Although the terminology is similar to the RBRVS, the two sets of relative values represent two different ways of comparing services. Accordingly, the Medicare program uses a different conversion factor for anesthesia services; in Montana in 2002 it is $15.11. Because of the legislatively mandated transition described above, the Medicaid conversion factor in July 2002 is $26.25. Without the transition, the Medicaid conversion factor would be $15.11.

Policy adjustor

Anesthesia codes for maternity and family planning procedures are paid 10% more than they would otherwise be paid.

Modifiers

Payment for anesthesia services is affected by the modifier pricing rules shown in the accompanying table; take note of the modifiers for anesthesia care provided under medical supervision. Medicaid follows Medicare in not paying extra for the patient status modifiers P1 to P6.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

When billing Medicaid for anesthesia services, enter the number of minutes in the "Units" field of the CMS-1500 claim form.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Professional differentials

In general, mid-level practitioners receive 90% of the fee that a physician would receive for the same service. The exception is that mid-level practitioners receive 100% of the fee for immunizations, family planning, drugs paid via HCPCS Level II codes, services to clients under age 21 (i.e., Well Child EPSDT services), lab and pathology services, radiology, cardiography and echocardiography (per ARM 37.86.205(6)).

Charge cap

The Department pays the lower of the provider's charge and the amount as calculated above.

Payment by report

Base units have not been developed for unlisted anesthesia services. These services are paid at a percentage of charges; in July 2002 the percentage was 51%.

Clinical Lab Services (ARM 37.85.212)

In general, Medicaid pays the same fees for clinical lab services as Medicare does in Montana. If a Medicare fee is not available for a lab test covered by Medicaid, then payment is calculated by looking at the average charge and the amounts paid by other payers.

Vaccines and Drugs Provided Within the Office

Many vaccines are available for free to physician offices through the Vaccines for Children (VFC) program. For more information on how to obtain these vaccines, call (406) 444-5580. For these vaccines, the Department does not pay separately. Medicaid does pay for the administration of the vaccine, however. For more information, see the *Billing Procedures* chapter in this manual.

Medicaid pays for vaccines not available through the VFC program, and for other drugs that have to be administered within the office or clinic setting. Medicaid pays average wholesale price less 15% for drugs. Average wholesale price is calculated by National Drug Code, a detailed coding system that is not shown on CMS-1500 bills. Instead, the bills show HCPCS Level 2 codes; almost all drugs are coded in the J series (for example, J2345). When a J code closely matches the NDC code for a particular drug, Medicaid pays for the drug directly. For other J codes, however, the claims processing system denies the line and requests that the provider send the NDC or invoice to the Department so that payment may be calculated.

How Cost Sharing Is Calculated on Medicaid Claims

Client cost sharing fees are a set dollar amount per visit (see the *Billing Procedures* chapter, *Client Cost Sharing,* for more information and a chart showing cost sharing amount by provider type). The client's cost sharing amount is shown on the remit-